

PEER REVIEW HISTORY

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ARTICLE DETAILS

TITLE (PROVISIONAL)	"Service providers' perspectives, attitudes and beliefs on health services delivery for Aboriginal people receiving haemodialysis in rural Australia: A qualitative study"
AUTHORS	Rix, Elizabeth; Barclay, Lesley; Wilson, Shawn; Stirling, Janelle; Tong, Allison

VERSION 1 - REVIEW

REVIEWER	Mcbain-Rigg, Kris James Cook University, Faculty of Medicine, Health & Molecular Sciences
REVIEW RETURNED	06-Aug-2013

THE STUDY	<p>his study was a qualitative study and thus did not utilise statistical analysis.</p> <p>The study itself is clearly part of a much larger project, as there are indications within the article that other data has been used to enhance the collection of the reported results (specifically, the use of the case studies that are adapted from interviews with Aboriginal patients). There are a number of times within the article that it would be of benefit to know more about the methodology which informs it (for example, in the COREQ Checklist, the author states that this is a grounded theory study, but has not indicated this anywhere within the article itself). I believe that the discussion of grounded theory and its applicability within health research would greatly benefit the article and would assist readers to better interpret the quality of the results.</p> <p>I would also like for the authors to elaborate on why it was necessary to provide three case studies as talking points, when the interview schedule was very comprehensive - what did the addition of these examples add to the quality of the conversations? How might these talking points impact on the kind of responses given by participants?</p> <p>Also, within the data collection section, could the authors please provide references to key concepts like theoretical saturation, as some readers may not know what this means, and may wish to pursue further reading about the concept and its relation to analysis of the data you have.</p> <p>In the analysis section it would be pertinent to elaborate again on how grounded theory impacts on the way you conduct inductive thematic analysis. These are important details for those assessing the quality of your research and its analysis, and in establishing trustworthiness given you were the sole researcher in charge of all steps of the research process (from design to interviews to</p>
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	<p>transcription to analysis, albeit with a team of knowledgeable others at your disposal). I was asked for similar levels of methodological and methods detail in constructing the paper of mine that you have quoted, and when translating this kind of research for a health audience, it is critical for them to understand this in order to decipher your research.</p> <p>There is mention at the end of the discussion section that the study has some limitations, but then only one is elaborated, and is not then adequately addressed why it is acceptable within this study: for some readers, it would not be acceptable for this information to have limited transferability (some readers may see this is a purely descriptive study and then fail to see the value of your results because of it). If you are going to mention the limitations of your work, you need to be able to defend why it is still a valid research project. Also, the article would benefit from a stronger focus on the strengths of the study. I think you need to elaborate how purposive sampling actually led to breadth of views - this almost seems contradictory, but I understand that you interviewed health staff that came from a number of disciplinary backgrounds - it would be of value to elaborate on which disciplinary backgrounds (not their specific jobs), in order to demonstrate that breadth of experience and perspective. Given that it appears that most of your participants agreed on key concepts in spite of their disciplinary differences, this is an important point to explore (if you are considering any kind of discourse analysis as part of future studies, for example).</p>
RESULTS & CONCLUSIONS	<p>There are some issues in the reporting of results that I would like to see clarified or amended. It can be very difficult to summarise the results of such interviews well, and especially given that the authors are attempting to provide statements addressing not only five major themes, but their underlying sub themes as well. Considering this, I believe that the authors have achieved this reasonably well.</p> <p>However, I do have concerns with the subtheme of "Outreach". I am uncertain on whether the problem lies in the titling of this theme or in its content. Currently the paragraph addressing this subtheme does not reflect the title - the details provided do not actually tell the reader about outreach, rather they point to issues regarding transportation and access for remotely located Aboriginal patients. I would suggest that what this theme is demonstrating is actually about the need for outreach service provision, not about outreach itself. Could I suggest the authors provide either a statement about whether outreach services are provided in the health service district in question, and how they are provided. It just seems as though what you are trying to communicate relates to a lack of outreach services to support those rural Aboriginal patients on HD, who find it difficult or impossible to travel for care. But at the moment it is a bit unclear how it relates to outreach. I would like to see a similar addition to the section "limited efficacy of cultural awareness training" - how is cultural awareness training delivered in the health service district? Is it system mandated or at the discretion of individual care providers to attend? Or perhaps this detail could be elaborated in discussion of the interaction between these themes.</p> <p>While most of the major themes contain an excellent summary of how the axial code was decided upon and how the subsequent subthemes were generated, there is one that does not contain such a statement: "Inadequate screening and diagnosis". I think that this is a glaring difference between the sections, and would like to see this amended.</p> <p>There is also an anomaly in reporting on page 13, where the first</p>

	<p>and only quotation to be used in the entire text appears. This the only direct quotation used within the text, but also does not directly relate to the theme that precedes it. My suggestion would be to supply a more relevant quote or better yet, leave it out altogether for consistency. Given the restrictive word limit I can see it has been difficult at times to provide adequate detail in the results, but I would also like to have seen more discussion of the interaction of these themes with each other, and with established literature of a similar ilk. This would assist the authors to make clear the important overlaps and gaps in the discussions of health professionals, and in pointing out the similarities and differences with other studies, which would enhance the article ability to suggest truly innovative findings, and not just be repeating more of the same. Grounded theory is useful in generating theories from the data, rather than fitting data into an established theory - so it would be valuable to know what original theories you have generated from this research that adds to established knowledge and expands on this, in relation to renal health care delivery.</p>
GENERAL COMMENTS	<p>I would suggest that the revisions you should focus on incorporate the following:</p> <p>Use as many of the remaining words you have available to you to elaborate on grounded theory in the methods section; clarify the title or elaborate on the subtheme of "Outreach" and "Limited efficacy of cultural awareness", as per my discussion above; provide a summary of your axial code in the section: "Inadequate screening and diagnosis"; better address the limitations and strengths of this research in your discussion; expand the concluding paragraph so that it addresses all of the issues raised in the abstract (it is just a bit short after such a good discussion).</p> <p>Removal of the quotation on page 13 - you have not included quotations elsewhere (other than those in Table 2). This would give you back some words to play with in addressing the rewrites above.</p> <p>Typology errors: Page 4 Line 48: removal of apostrophe after "health care providers". Page 10 Line 6: missing letter s on the word "relationship". Page 15 Line 15: Missing full stop.</p> <p>Thank you for providing me with the opportunity to complete this review. I would be happy to review further versions of this paper, and wish the authors all the best in their future research on this important topic.</p>

REVIEWER	Griva, Konstatina National University of Singapore, Psychology
REVIEW RETURNED	11-Aug-2013

THE STUDY	<p>This is an interesting paper, which attempts to explore factors that hinder or challenge delivery of health care for Aboriginal people established on hemodialysis. Chronic kidney disease is increasingly common, has a major impact on people's lives, and health care delivery in the context of different ethnic groups and culture is relatively understudied, so the paper has the potential to make a contribution to understanding and possibly to practice.</p> <p>The MS was generally well written and easy to read. There are</p>
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	<p>however some issues that need to be addressed.</p> <p>Overall, I strongly endorse the premise that more ethnically diverse patient groups are in need of further study yet the paper needs to make a better/stronger case for the potential contribution of the current study.</p> <p>The overview of past literature is relevant however it is brief and there is no indication as to how original this study's aims and findings are, both in Australia and worldwide. Although the cultural group in focus may not be a growing segment in other settings/countries, the international relevance of the topic should be explicated in the introduction section of the paper.</p> <p>To strengthen the study rational, it would be useful to expand more on evidence related to clinical and patient reported outcomes in Aboriginals with ESRD. What is the evidence that these groups are faring worse than other patient segments. The authors need to comment on what poor treatment outcomes refer to (see page 4) – there is for instance recent evidence to show that mortality rates are comparable between indigenous and non Indigenous Australians (See Marley et al. 2010).</p> <p>Methodology needs some clarification especially related to the use of case studies prior to conducting the interviews. The authors state that these were used to stimulate discussion yet these may have restricted focus to problematic aspects related to interactions and experiences with health care system and perhaps unnecessarily hence probe/force interviewees to attempt to explain these rather than share more spontaneously their perspectives on health services and delivery for their Indigenous patients. It would have been interesting to see if health service providers are indeed aware of any problematic interactions or delivery of care for this group of patients.</p> <p>I would also like to see a little more explanation of the determination of the size of the sample. Was analysis conducted alongside data collection, which is more typical of a grounded theory approach? It is stated that sample for purposefully sampled to ensure spread on related disciplines, age, gender and years of experience. The latter information (i.e., years of experience) however is not included in relevant table 1 on participants' characteristics. It would be useful to add years of experience in Table 1 as age per se may not necessarily imply longer time working with the patient group.</p> <p>REFERENCES Marley JV, Dent HK, Wearne M, Fitzclarence C, Nelson C, Siu K, Warr K, Atkinson D. Haemodialysis outcomes of Aboriginal and Torres Strait Islander patients of remote Kimberley region origin. Med J Aust. 2010 Nov 1;193(9):516-20</p>
GENERAL COMMENTS	<p>The conclusion section summarizes main findings and provides a good discussion of their implications for practice or policy. In light of evidence on need and family based care, it may be useful to comment on role peritoneal dialysis modalities for indigenous patients as way to promote and expand home based dialysis.</p> <p>The inclusion of HD only renal staff may have limited consideration of issues related to care for indigenous patients on PD regimes. This point needs to be stated in study limitations. Albeit HD is the mainstay for renal replacement therapy, there is emphasis on expanding PD. Discussion should touch upon these issues as implications and recommendations for further work.</p>

VERSION 1 – AUTHOR RESPONSE

Reviewer 1:

2. There are a number of times within the article that it would be of benefit to know more about the methodology which informs it (for example, in the COREQ Checklist, the author states that this is a grounded theory study, but has not indicated this anywhere within the article itself). I believe that the discussion of grounded theory and its applicability within health research would greatly benefit the article and would assist readers to better interpret the quality of the results.

As advised, we have added an additional paragraph to expand on our use of grounded theory: “While not assuming to generate new theory with a relatively small circumscribed study in one location, the methods for this study were adapted from grounded theory. This was an appropriate methodology for beginning to develop relevant theory grounded in the participants’ perspectives to inform health service delivery”[1]. (Page 7, paragraph 1)

3. I would also like for the authors to elaborate on why it was necessary to provide three case studies as talking points, when the interview schedule was very comprehensive - what did the addition of these examples add to the quality of the conversations? How might these talking points impact on the kind of responses given by participants?

We have added a paragraph to explain the use of three case studies as talking points, “Based on interviews with 18 rural Aboriginal patients on HD these case studies encompassed the key concerns identified by patients. Participants were asked to read the case studies prior to being interviewed. This helped to ensure that the interviews covered issues that were important to patients. This strategy was useful in eliciting participants’ levels of cultural knowledge, attitudes and beliefs, based on “real life scenarios in a non-confronting manner. This approach accords with grounded theory where ‘the entire research process is interactive...we bring past interactions and current interests into our research, and we interact with our empirical materials and emerging ideas’ [2]” (Page 6, paragraph 1)

4. Also, within the data collection section, could the authors please provide references to key concepts like theoretical saturation, as some readers may not know what this means, and may wish to pursue further reading about the concept and its relation to analysis of the data you have.

As suggested, we have added the following references for purposive sampling [1] (Page 5, paragraph 3) and theoretical saturation [3] (page 6 paragraph 2).

5. In the analysis section it would be pertinent to elaborate again on how grounded theory impacts on the way you conduct inductive thematic analysis. These are important details for those assessing the quality of your research and its analysis, and in establishing trustworthiness given you were the sole researcher in charge of all steps of the research process (from design to interviews to transcription to analysis, albeit with a team of knowledgeable others at your disposal). I was asked for similar levels of methodological and methods detail in constructing the paper of mine that you have quoted, and when translating this kind of research for a health audience, it is critical for them to understand this in order to decipher your research.)

As advised, we have added the text (underlined) to provide further details about the analysis: “Concepts were documented inductively, grouping similar or overlapping themes, patterns, relationships and common or divergent perspectives. This method followed Strauss’s grounded theory ‘coding paradigm’, where theories are developed by interaction with the data. Coding moves from open (opening up the data to develop concepts) through to axial (the coding focuses around developing concepts) to selective coding (focusing on one category at a time). Explanations are

discussed, reflected upon and built from dense coding [4] (Page 7, paragraph 1). To enhance the analytical framework and ensure rigour, interpretation of the data and emergent themes were discussed with members of the research team. Member checking was conducted by returning transcripts to participants to check for accuracy and inviting participants to meet and discuss the preliminary analysis. Participants confirmed the analysis and themes reflected their perspectives, attitudes and beliefs about service provision to Aboriginal people receiving HD. The first author used self-reflexivity to check for potential biases from her dual clinician/researcher role, that may have influenced decision making throughout the study [5 6].” (Page 8, paragraph 1)

6. There is mention at the end of the discussion section that the study has some limitations, but then only one is elaborated, and is not then adequately addressed why it is acceptable within this study: for some readers, it would not be acceptable for this information to have limited transferability (some readers may see this is a purely descriptive study and then fail to see the value of your results because of it). If you are going to mention the limitations of your work, you need to be able to defend why it is still a valid research project.

As suggested, we have expanded our discussion on the study limitations, “Validity and accuracy of the data analysis was thus enhanced by seeking multiple perspectives (i.e. triangulation) including: patient perspectives gained from a reference group of Aboriginal renal patients and Elders who guided the study; confirmation by discussions with participants; and involving multiple researchers from different disciplines in the analysis [5].” (page 7, paragraph 2)

7. Also, the article would benefit from a stronger focus on the strengths of the study. I think you need to elaborate how purposive sampling actually led to breadth of views - this almost seems contradictory, but I understand that you interviewed health staff that came from a number of disciplinary backgrounds - it would be of value to elaborate on which disciplinary backgrounds (not their specific jobs), in order to demonstrate that breadth of experience and perspective. Given that it appears that most of your participants agreed on key concepts in spite of their disciplinary differences, this is an important point to explore (if you are considering any kind of discourse analysis as part of future studies, for example).

As advised, we have included an additional paragraph to state, “We would however argue that our use of purposive sampling gave considerable strength to this study by including a diverse and broad range of perspectives and experience, therefore increasing the potential for transferability of findings and recommendations for service delivery to Aboriginal people experiencing renal disease in other rural communities [7].” (Page 20, paragraph 1)

“Participants were identified by consulting senior clinicians and Aboriginal health workers. There were 23 non-Aboriginal and 6 Aboriginal participants. Disciplines included in the sample were: medical, nursing (renal, community and nurse practitioner), renal case managers, hospital management, health policy, social work, Aboriginal health workers and Aboriginal liaison officers.” (Page 5, paragraph 3)

8. There are some issues in the reporting of results that I would like to see clarified or amended. It can be very difficult to summarise the results of such interviews well, and especially given that the authors are attempting to provide statements addressing not only five major themes, but their underlying sub themes as well. Considering this, I believe that the authors have achieved this reasonably well. However, I do have concerns with the subtheme of "Outreach". I am uncertain on whether the problem lies in the titling of this theme or in its content. Currently the paragraph addressing this subtheme does not reflect the title - the details provided do not actually tell the reader about outreach, rather they point to issues regarding transportation and access for remotely located Aboriginal patients. I would suggest that what this theme is demonstrating is actually about the need for outreach service provision, not about outreach itself. Could I suggest the authors provide either a statement

about whether outreach services are provided in the health service district in question, and how they are provided. It just seems as though what you are trying to communicate relates to a lack of outreach services to support those rural Aboriginal patients on HD, who find it difficult or impossible to travel for care. But at the moment it is a bit unclear how it relates to outreach.

As suggested, we have renamed the sub-theme and further clarified its meaning (underlined):

“Transport and access: (page 8 paragraph 4) Most participants were aware of major logistical challenges for rural Aboriginal people accessing HD. Many believed poor transport arrangements restricted access and patients’ ability to attend dialysis and the other frequent appointments renal patients require. Participants described many instances of Aboriginal patients’ negative outcomes resulting from poor access, for example: inability to attend podiatry appointments resulting in reduced or loss of mobility.” (Pages 8-9, paragraph 4&1)

9. I would like to see a similar addition to the section "limited efficacy of cultural awareness training" - how is cultural awareness training delivered in the health service district? Is it system mandated or at the discretion of individual care providers to attend? Or perhaps this detail could be elaborated in discussion of the interaction between these themes.

“Some participants who had attended the one day cultural awareness training felt that it reinforced differences between Aboriginal and non-Aboriginal people in a negative way, providing insufficient education to counter stereotyping and commonly held assumptions. Others felt that regular, ongoing training could be more effective in addressing current shortfalls in non-Aboriginal staffs’ cultural knowledge. Aboriginal cultural awareness training is deemed mandatory for healthcare professionals within this health service, however the majority of participants reported they had not been given the opportunity to attend the one day session. While this training was deemed ‘mandatory’ most participants believed there were inadequate resources for sufficient training places or to backfill clinical staff to attend.” (pages 9-10, paragraph 3&1)

10. While most of the major themes contain an excellent summary of how the axial code was decided upon and how the subsequent subthemes were generated, there is one that does not contain such a statement: "Inadequate screening and diagnosis". I think that this is a glaring difference between the sections, and would like to see this amended.

As suggested, we have amended this to: “The majority of participants voiced their awareness of Aboriginal people frequently being diagnosed late in the progression of their disease. Aboriginal informants working with renal patients and several non-Aboriginal participants felt that this was due to Aboriginal people’s inherent mistrust of mainstream health services. There were also comments about many Aboriginal people having had family members pass away or experience high levels of trauma, resulting in their avoidance of screening from fear of being diagnosed with kidney disease themselves” (Page 13, paragraph 1)

11. There is also an anomaly in reporting on page 13, where the first and only quotation to be used in the entire text appears. This the only direct quotation used within the text, but also does not directly relate to the theme that precedes it. My suggestion would be to supply a more relevant quote or better yet, leave it out altogether for consistency.

We have deleted the quotation as suggested. (Page 16, deleted paragraph 2)

12. Given the restrictive word limit I can see it has been difficult at times to provide adequate detail in the results, but I would also like to have seen more discussion of the interaction of these themes with each other, and with established literature of a similar ilk. This would assist the authors to make clear the important overlaps and gaps in the discussions of health professionals, and in pointing out the

similarities and differences with other studies, which would enhance the article ability to suggest truly innovative findings, and not just be repeating more of the same. Grounded theory is useful in generating theories from the data, rather than fitting data into an established theory - so it would be valuable to know what original theories you have generated from this research that adds to established knowledge and expands on this, in relation to renal health care delivery.

As suggested, we have described key relationships between themes in the results section:

Interrelation of themes

The five themes link together under the overarching theme of 'Systemic cultural understanding will provide better services' (Figure 1.). Each theme relates to this major theme, with most participants acknowledging that there is a systemic lack of cultural safety impacting on service delivery and health outcomes for rural Aboriginal renal patients. A basic mistrust of mainstream services is a barrier to early screening and detection. When eventually detected, issues of transport and access to community renal nurses make it difficult to keep people at home once they commence HD. When patients are forced to travel to in-centre HD, inadequate cultural awareness of staff and perceptions of pervasive institutionalised racism, compound to make hospital based treatment culturally unsafe for Aboriginal people. (Page 15-16, paragraph 4&1)

In the discussion, we have added a paragraph to expand on the original explanations we generated. Studies in remote and metropolitan settings have found that lack of cultural safety and access issues have major implications for the well-being of Aboriginal renal patients[8-11]. This paper reports similar challenges for rural dwelling renal patients, recommending strategies to address these. A study 2010 in remote Australia demonstrated that provision of culturally appropriate services, provided by an Aboriginal Controlled Medical Service has resulted in Aboriginal HD outcomes being comparable with those of non-Aboriginal Australians [12] (Page 17, paragraph 2)

13. I would suggest that the revisions you should focus on incorporate the following: Use as many of the remaining words you have available to you to elaborate on grounded theory in the methods section; clarify the title or elaborate on the subtheme of "Outreach" and "Limited efficacy of cultural awareness", as per my discussion above; provide a summary of your axial code in the section: "Inadequate screening and diagnosis"; better address the limitations and strengths of this research in your discussion; expand the concluding paragraph so that it addresses all of the issues raised in the abstract (it is just a bit short after such a good discussion).

As suggested, we have incorporated these. Please refer to our response to Point 7, 8, 9, and 10 above.

We have strengthened the conclusions with a rewrite including additional statements:

Service providers believe current services are not designed to address cultural needs and Aboriginality, and that caring for Aboriginal patients receiving haemodialysis should be family-focussed and culturally safer. Prioritising prevention by increased screening and education about kidney disease is paramount. An Aboriginal specific pre-dialysis pathway, building staff cultural awareness and enhancing cultural safety within hospitals are recommended. Increasing patient support for home haemodialysis may improve health and quality of care outcomes. Implementing the recommendations from this study may also help in addressing patient mistrust of mainstream health services and reduce the impact of institutionalised racism on Aboriginal renal patients. (Page 20, paragraph 2)

14. Removal of the quotation on page 13 - you have not included quotations elsewhere (other than those in Table 2). This would give you back some words to play with in addressing the rewrites above.

As suggested, we have deleted the quotation. (Page 16, paragraph 2)

15. Typology errors: Page 4 Line 48: removal of apostrophe after "health care providers"; Page 10 Line 6: missing letter s on the word "relationship". Page 15 Line 15: Missing full stop.

These have been amended accordingly.

Reviewer 2:

16. Overall, I strongly endorse the premise that more ethnically diverse patient groups are in need of further study yet the paper needs to make a better/stronger case for the potential contribution of the current study. The overview of past literature is relevant however it is brief and there is no indication as to how original this study's aims and findings are, both in Australia and worldwide. Although the cultural group in focus may not be a growing segment in other settings/countries, the international relevance of the topic should be explicated in the introduction section of the paper.

As advised, we have added the following in the introduction: "Similar disparities and challenges exist for Indigenous peoples of other first world nations, for example Canada, New Zealand and the United States [13 14]." (Page 4, paragraph 1)

17. To strengthen the study rational, it would be useful to expand more on evidence related to clinical and patient reported outcomes in Aboriginals with ESRD. What is the evidence that these groups are faring worse than other patient segments. The authors need to comment on what poor treatment outcomes refer to (see page 4) – there is for instance recent evidence to show that mortality rates are comparable between indigenous and non Indigenous Australians (See Marley et al. 2010).

Thank you for this comment. We do know of this paper, however it reports outcomes for remote patients, with one very important difference in service delivery from the rural patients in our study. The Kimberly renal service is located in their country and has been operated by an Aboriginal Community Controlled Medical Service since 2002 which is a culturally appropriate. On page 516 the authors state that they investigated the outcomes for Aboriginal and Torres Start Islander patients because of this new model of care, the study took place from 2003-2007. Additionally, the majority of their patients were commenced on PD before starting HD, which is not the case in the rural region within this study. Of the 18 Aboriginal patients interviewed for a phase one of this study in this rural region, only one had previously received PD.

To address this gap in the evidence we have added the following to the introduction: "Australian Aboriginal people suffer higher levels of mortality and morbidity from kidney disease than non-Aboriginal Australians[15]. Diabetes is a leading contributor to ESKD and is a co-morbidity in the majority of patients, with frequent poor management of blood pressure and glycaemic control also contributing factors [16 17]. Socio-economic disadvantage and late referral to a nephrologist are also known to increase morbidity and decrease survival time for ESKD patients [18 19]." (Page 4, paragraph 2)

18. Methodology needs some clarification especially related to the use of case studies prior to conducting the interviews. The authors state that these were used to stimulate discussion yet these may have restricted focus to problematic aspects related to interactions and experiences with health care system and perhaps unnecessarily hence probe/force interviewees to attempt to explain these rather than share more spontaneously their perspectives on health services and delivery for their Indigenous patients. It would have been interesting to see if health service providers are indeed aware of any problematic interactions or delivery of care for this group of patients.

Thank you for this perspective, however we believe the case studies enhanced the interviews, enabling participants to reflect and comment on the challenges facing their Aboriginal patients, as

they were described in phase one of this study. The aim of these interviews was to elicit providers' perceptions, attitudes and beliefs, with the interview technique using a combination of the 'real life' case studies and set questions working very well in eliciting attitudes and beliefs that may not have emerged with only the questions. The case studies were piloted with several of the first author's renal nurse colleagues, who gave positive feedback afterwards and appreciated the case studies as a tool to focus them on the major challenges for the patients under their care. They were developed in consultation with several senior clinicians and researchers. See the above paragraph added to the methods section justifying the use of case studies.

We have added the following sentence regarding the development and piloting of the case studies:

"To stimulate discussion, participants were asked to read three case studies that were adapted from interviews with Aboriginal clients of the services (Appendix A). These were developed in consultation with senior clinicians and piloted on several renal nurses, who gave positive feedback on how these 'real life' scenarios enabled them to focus on the challenges facing their Aboriginal patients." (Page 6, paragraph 1)

19. I would also like to see a little more explanation of the determination of the size of the sample. Was analysis conducted alongside data collection, which is more typical of a grounded theory approach?

To clarify, "Data analysis was conducted concurrently during data collection in accord with grounded theory methods [2]. Theoretical saturation was reached at approximately 24 interviews, however with a total of 29 of 31 invitees responding and wanting to be participants, it was considered respectful and appropriate to interview all 29." (Page 6, paragraph 2)

It is stated that sample for purposefully sampled to ensure spread on related disciplines, age, gender and year

20. s of experience. The latter information (i.e., years of experience) however is not included in relevant table 1 on participants' characteristics. It would be useful to add years of experience in Table 1 as age per se may not necessarily imply longer time working with the patient group.

As suggested, we have included years of experiences to Table 1.

Years of experience working with Aboriginal renal patients

(n) %

<5 2 (7)

6-10 9 (31)

11-20 11 (38)

>20 7 (24)

21. The conclusion section summarizes main findings and provides a good discussion of their implications for practice or policy. In light of evidence on need and family based care, it may be useful to comment on role peritoneal dialysis modalities for indigenous patients as way to promote and expand home based dialysis. The inclusion of HD only renal staff may have limited consideration of issues related to care for indigenous patients on PD regimes. This point needs to be stated in study limitations. Albeit HD is the mainstay for renal replacement therapy, there is emphasis on expanding PD. Discussion should touch upon these issues as implications and recommendations for further work.

PD is not currently offered to Aboriginal patients by nephrologists in the rural region where this study took place, and anecdotally it is known there was only one Aboriginal HD patient within the service who had previously received PD. Additionally, the issues for patient on PD are quite different in rural

areas, because patients can perform their own dialysis at home, therefore travelling and access issues are different. We have however added the following sentence to limitations: “

“This study has focussed on services for Aboriginal people on HD only and not included peritoneal dialysis (PD) because there were no Aboriginal patients receiving PD in the rural region at the time of this study. Further research exploring service delivery for Aboriginal people receiving PD is recommended.” (Page 20, paragraph 1)

Added references

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